

RICHARDSON BAY REGIONAL AGENCY

TITLE VI/504/ADA and Related Federal and State Statutes Discrimination Complaint Form

Name of Complainant: _____

Home Telephone Number: _____

Work Telephone Number: _____

Mailing Address: _____

What is the most convenient time for us to contact you about this complaint? _____

Basis of Discriminatory Action(s):

- | | |
|---|---|
| <input type="checkbox"/> Race | <input type="checkbox"/> Religion/Creed |
| <input type="checkbox"/> Sex | <input type="checkbox"/> Physical/Mental Disability |
| <input type="checkbox"/> Marital Status | <input type="checkbox"/> Genetic Information |
| <input type="checkbox"/> Color | <input type="checkbox"/> Age |
| <input type="checkbox"/> National Origin/Ancestry | <input type="checkbox"/> Medical Condition |
| <input type="checkbox"/> Veteran's Status | <input type="checkbox"/> Retaliation |

Date and place of alleged discriminatory actions. Please include earliest date of discrimination and most recent date of discrimination:

How were you discriminated against? Describe the nature of the action, decision, or conditions of the alleged discrimination. Explain as clearly as possible what happened and why you believe your protected status was a factor in the discrimination. Include how other persons were treated differently from you. (Attach additional page(s), if necessary).

Names of persons (witnesses, fellow employees, supervisors, or others) whom we may contact for additional information to support or clarify your complaint: (Add additional pages if necessary.)

Name(s):

Address(es):

Telephone Number(s):

Signature of Complainant

Date